IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 10/23/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Anterior Cervical Discectomy Fusion, C5/6, C6/7 (1 day inpatient stay)

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female who was injured on XX/XX/XX when xxxxx. The patient had been followed for complaints of pain in the neck and shoulder regions as well as the upper and low back regions radiating to the lower extremities. The clinical records note completion of physical therapy as well as several medications including anti-inflammatories and muscle relaxers. The patient underwent one prior epidural steroid injection to the left at C6-7 with temporary improvement only. MRI studies of the cervical spine from xxxx noted degenerative changes at C5-6 and C6-7 with a with 4mm disc protrusions at each level impressing the cervical cord as well as impinging the left C6 nerve root. There was also mild right neural foraminal narrowing noted. A CT myelogram study of the cervical spine from xxxx noted extradural defects at multiple levels from C2 to C6 with a Tarlov cyst present at C7-T1. The study noted effacement of the anterior epidural space with central stenosis that was mild to moderate in severity at C5-6. There was a mild right neural foraminal narrowing that was a mild amount of right neural foraminal narrowing with no evidence of left sided neural foraminal stenosis. At C6-7 there was mild to moderate central stenosis without neural foraminal narrowing due to disc bulging. The patient was evaluated on xxx and found to have no contraindications for surgical intervention. The patient had been followed recently with the xxxxx evaluation noting continuing neck pain and low back pain that had not improved over time. The patient still described numbness and tingling radiating to the cervical region into the left hand. The patient's physical examination still noted tenderness at the cervical and thoracic regions with limited range of motion. There were no focal neurological deficits noted. The proposed two level anterior cervical discectomy and fusion at C5-6 and C6-7 was denied by utilization review on xxxxx as there was no evidence regarding radiculopathy consistent with MRI studies in the cervical spine or other evidence of instability in the cervical spine. The request was again denied by utilization review on xxxxx due to no clear evidence regarding cervical radiculopathy.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical documentation submitted the patient was noted to have continued to have complaints of neck pain radiating to the left upper extremity with associated numbness and tingling despite non-operative management to include medications physical therapy and one selective nerve root block. The patient's most recent evaluations did not identify any focal neurological deficits involving the upper extremities. Imaging studies to include the most recent CT myelogram of cervical spine did not identify any evidence of left sided nerve root impingement or encroachment due to disc pathology that would support an active radiculopathy that would require surgical intervention. As the prior reviewer's concerns regarding lack of evidence regarding radiculopathy were not addressed by the clinical records available for review, it is this reviewer's opinion the medical necessity for request has not been established the prior denials remain upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)